Mississippi Department of Mental Health
Division of Certification
Notification Form for Inability to Place Pregnant Woman

INSTRUCTIONS: This standardized form should be used to notify the Department of Mental Health (DMH) of the inability to place a pregnant woman within 48 hours from the initial request for treatment for all agency providers certified to provide services within the public mental health system for individuals with substance use disorders (SUD). (*Operational Standards* Rule 49.4). Please read carefully, complete this form, submit it to DMH within the required timeframe, and retain a copy for your records. All attachments should be submitted with the completed form. Please type or print legibly. This form must be completed by the individual or governing body with the authority and responsibility for developing policies, procedures, and business practices for which the agency and its services will be operated. This may include the executive director, chairperson of the governing authority, owner, etc. All dates should include the month, date, and year. Original signatures must be included.

Section A

Contact Information: Please include the contact information for the Executive Director/Top-Level Administrator who is signing this Notification Form.

Agency Name: _____

Executive Director/Top-Level Administrator Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same as street address): _____

City: _____ State: _____ Zip Code: _____

Telephone Number (Primary): _____ (Secondary): _____

Email Address: _____

DMH Certification Number: _____

Section B

Client Information: Please fill out this section pertaining to the individual that was unable to be placed due to pregnancy.

Client Name: _____
Client ID/Case Number: _____
Date of Initial Request for Treatment: _____

Reason for Inability to Place:

At Capacity: ☐
Other (Please specify): _____

_____

Actions Taken:

Assessment Conducted:

- Date of Assessment: _____
- Conducted by (Name and Title): _____

Referral Information:

- Referred to (Agency Name): _____
- Contact Person at Referred Agency: _____
- Contact Phone Number: _____
- Date of Referral: _____

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Interim Services Provided:
Referred to Local Health Provider for Prenatal Care: ☐
Other (Please specify): _____

_____

Follow-Up Actions:
Date Follow-Up Conducted: _____
Outcome of Follow-Up: _____

Additional Comments: _____

_____

Notification to DMH:
Date of Notification: _____
Method of Notification: ☐ Email
Email Address Used: _____

Section C

Statement of Assurance: The individual signing must be the proprietor in the case of a sole proprietorship, the Executive Director or chair of the governing authority of a corporation, governmental entity, or individual identified and granted authority by the University, certifying that the information provided is accurate and that all required actions have been taken in accordance with *Operational Standards* Rule 49.4.

Signature	Date

Type or Print Name and Title of Individual Signing

Witness Signature:
Name: _____ **Title:** _____ **Date:** _____

For DMH Use Only:
Received By: _____ **Date:** _____